

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1801	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF CROSSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 80 JUSTICE ST CROSSVILLE, TN 38555		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	<p>1200-8-6 No Deficiencies</p> <p>This Rule is not met as evidenced by: Complaint investigation #30521 was conducted on October 8, 2012, at Life Care Center in Crossville. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.</p>	N 002			

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

UTB711

If continuation sheet 1 of 1